

**CRIPPLE CREEK-VICTOR SCHOOL DISTRICT RE-1  
STUDENT HEALTH INFORMATION**

School Year: \_\_\_\_\_

**STUDENT NAME:** \_\_\_\_\_ **Birthdate:** \_\_\_\_ / \_\_\_\_ / \_\_\_\_ **Grade:** \_\_\_\_

**School Attending: (Circle One)      CCV JR/SR High      Cresson**

HEALTH CONDITIONS	YES	NO	MEDICATION(S)	WILL THIS REQUIRE MONITORING IN SCHOOL?	ADDITIONAL COMMENTS
ASTHMA					
DIABETES					
HISTORY OF HEAD INJURY					
IMMUNE CONDITIONS					
MIGRAINES					
MUSCLE/JOINT/BONE					
SEIZURES					
SKIN CONDITIONS					
STOMACH/BOWELS/DIGESTIVE					

**PLEASE LIST ANY ALLERGIES TO MEDICATIONS / FOODS / LATEX / OTHER SUBSTANCES:**

\_\_\_\_\_

\_\_\_\_\_

Does your child wear glasses or contacts? **Y / N**      **Circle One:** READING ONLY / DISTANCE ONLY / FULL TIME

Does your child wear hearing aids? Do they have hearing loss?

Health Care Provider Name: \_\_\_\_\_

Phone: \_\_\_\_\_

**PARENT/GUARDIAN SIGNATURE:** \_\_\_\_\_ **TODAY'S DATE:** \_\_\_\_\_

**HOME ADDRESS:** \_\_\_\_\_ **CITY** \_\_\_\_\_ **ZIP CODE** \_\_\_\_\_

**MAILING ADDRESS:** \_\_\_\_\_ **CITY** \_\_\_\_\_ **ZIP CODE** \_\_\_\_\_

**PHONE NUMBER(S) WHERE WE CAN ALWAYS REACH YOU:**

\_\_\_\_\_

\_\_\_\_\_